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NOTES OF CASES OF PLEURISY TREATED WITH PARACENTESIS THORACIS, AND PERMANENT OPENING.

BY HALL CURTIS, M. D.,

Visiting Physician at the Boston City Hospital.

CASE XIII. Frederick L., a Swede, aged twenty-three, single, and a painter by occupation, entered the hospital March 17, 1875. He had been sick three months with cough and pain in the side; was tapped last December, and two pints of serum were removed. He became better, but still was not able to work. His dyspnœa increasing, he was again tapped one week before entrance to the hospital, and pus was withdrawn. At entrance, slight dullness was found at the upper right front, with tubular respiration and moist râles. There was good resonance in the left front, with modified respiratory murmur, somewhat amphoric on coughing or speaking. The right back was normal. In the left back the respiratory murmur was modified at the upper half; in the lower half it was very faint, with the amphoric character on coughing or speaking. Nothing was observed on succussion. Heart normal. Temperature, evening of entrance, 101°; pulse 128.

March 29th. Moist râles heard throughout right front. No respiratory murmur below spine of scapula in left back. Complete flatness in lower half.

April 1st. A splashing sound was heard on succussion.

April 2d. A pint of pus was withdrawn by the aspirator, the trocar being introduced one and three quarters inches below the inferior angle of the scapula. An incision was made into the cavity of the pleura at this place, giving vent to two pints of pus. A drainage tube was introduced, and within one hour two more pints of laudable pus flowed out.

April 3d. Patient much more comfortable; rested well last night. Pleura washed out night and morning with tepid carbolized water. Patient takes nourishment freely; has four ounces of brandy daily. Temperature 99° A. M.; 100.2° P. M.

April 6th. Patient did not sleep well last night. Discharge somewhat offensive. Respiration through left back feeble, and faintly heard nearly to inferior angle of scapula. Temperature 99° A. M.; 101.2° P. M.

April 10th. A daily discharge of from one to two gills of creamy pus, not very offensive. Right chest clearer at base, but mucous râles through upper half. Temperature 100° A. M. ; 102.2° P. M.

April 11th. Patient seems to be failing. Discharge very offensive. Pleura washed out three times daily. Temperature 99.8° A. M. ; 103.2° P. M.

April 18th. Condition about the same. Half a pint of laudable pus discharged to-day. The cavity growing smaller. Temperature the past four days has varied from 98° and 100° A. M., to 103° and 104° P. M.

April 21st. Two gills of pus discharged this morning. Patient seems better, though still quite weak ; coughs occasionally during the washing out. Temperature 98.5° A. M.

April 23d. No improvement since last record. Coarse râles and gurgling in the upper half of the right chest, with some friction-sounds at the base. Respiration is heard in the left front to within an inch of the nipple ; behind, respiration is heard to the angle of the scapula ; occasionally squeaking sounds at that point, and friction sounds below. Temperature 96.8° A. M. ; 96.2° P. M. The patient sank gradually, and died April 26th. No autopsy.

CASE XIV. Michael J. O'C., an unmarried Irishman, aged forty-two years, a bottle-maker, stated that he had not been well for six months ; he had lost flesh and strength. He complained of cough, with pain in the chest, shoulders, and loins ; no hæmoptysis. Physical examination revealed dullness in the left supra-scapular region, with broncho-vesicular respiration, and occasionally a moist râle. The respiration below this was somewhat bronchial in character. There was some dullness in the lower right back, with respiratory murmur very much modified and with bronchophony. Heart normal.

April 7th. Dullness under the right clavicle and want of tone in the lower fourth. Respiration rude through the upper third, with an occasional moist râle in lower half. Respiration puerile in the left front.

April 15th. Area of hepatic dullness increased from the nipple to one inch below the ribs, with tenderness on pressure. Superficial veins of abdomen enlarged.

May 13th. The liver had resumed its usual limits, and the patient was out every day. There was still want of tone and absence of respiration in lower fourth of the right back. The aspirator with exploring trocar was used, and four ounces of serum were withdrawn.

May 17th. Respiration was heard to the base of the right back. The patient was discharged, relieved.

CASE XV. Mary C., aged twenty-seven, a domestic, entered the hospital April 1, 1875. One sister had died of consumption. The patient was well till March 1, 1875. She had been sleeping in a cold,

damp cellar all winter, and had worked very hard. She had been troubled with dyspnœa and cough at night, and with nausea in the morning; had lost flesh; had had night-sweats, but no hæmoptysis. There was dullness in the lower half of the left back, with modified respiratory murmur, and a few moist râles. The right back was normal. There was dullness in the left front, with modified respiratory murmur and dry râles. No bronchophony. The right chest had good resonance and exaggerated respiratory murmur.

April 28th. The heart was found pushed to the right side; apex beat in the epigastrium. Left front dull; respiration distant and bronchial below the third rib; left back as on the 10th. The left side was more prominent and had less expansion. Profuse night-sweats; not relieved by atropine. Tincture of iodine was applied to the back and side.

May 16th. No improvement. Absence of respiration below the angle of the scapula, and below fourth rib in front. Patient complained of increasing dyspnœa. The needle of the aspirator was introduced one and one half inches below the inferior angle of the scapula, and a pint and a half of clear serum withdrawn.

May 20th. Patient says she is much more comfortable and breathes easier. The left front is dull throughout. Respiration absent below the third rib (when patient is lying down). Left back the same as before the operation. Aspirator again used; the needle was inserted twice, but no fluid followed. Tincture of iodine was continued.

June 3d. Good resonance to inferior angle of the left scapula; below this dullness and absence of respiration; no bronchophony. General condition improving.

June 23d. An exploratory puncture was made by Dr. Blake and half a gill of clear serum withdrawn. Discharged June 30th, relieved.

The patient returned to the hospital for other trouble in September, and was under the care of Dr. Draper, who made the following note: "Modified resonance throughout the left back. Dullness at the base. Respiration heard two inches below the scapula."

CASE XVI. C. C., aged forty, a hypochondriac, with a history of pleurisy. Intermittent fever and hepatitis. The first of February had an attack of pleurisy and was confined to bed four weeks. He entered the hospital May 6, 1875.

Physical examination revealed the following condition. The right chest was one and a half inches larger than the left; the intercostal spaces were not prominent. Expansion was diminished. Dullness through the right back, becoming flat in lower fourth. On ordinary respiration, the breathing was very distant over the upper two thirds of the right back, and absent below. With full respiration, the breathing was exaggerated in the upper fourth, and tubular over the rest of

the right back. Somewhat masked by friction sounds. In the left back the respiration was puerile. The right front was relatively dull. The respiration was distant through the upper half of the right chest; absent in the lower half. There was some specific history. The abdominal veins were enlarged. Liver dullness in mammary line, six inches; spleen normal. An exploratory puncture was made, and half a pint of clear serum was removed.

May 18th. Respiration heard clearly to one and a half inches below inferior angle of scapula; distant below; lower half of right back still dull.

May 30th. Respiration heard throughout right back. Some want of tone in lower fourth. Discharged, well.

CASE XVII. C. M., a Nova Scotian, aged nineteen, a carpenter by occupation, entered City Hospital April 12, 1875; he had been well till sixteen days before entrance. He was then troubled with general malaise and loss of appetite. He kept up and about till nine days before his admission; at that time took to his bed. During the week before his entrance he had diarrhœa, and, on one occasion, epistaxis. He was now in bed with headache, a brown tongue, and dry sordes on the teeth; his belly was tympanitic and tender, with a number of rose spots at the upper part; five dejections.

He steadily improved till May 10th, when dullness was found in upper part of the right chest.

May 19th. Dullness over right front; in lower half there was cracked-pot resonance. Breathing distant throughout, with moist râles above and amphoric respiration below. In the left chest the respiration was puerile. The upper third of the right back was dull; the lower two thirds flat; respiration bronchial, most marked in the lower half, with moist râles and becoming very distant at base. Right side rounded. Expansion diminished; absence of vocal fremitus. Cough troublesome, night-sweats.

May 25th. Aspirated; half a pint of rather dirty-looking pus, with air, withdrawn.

May 26th. Diminished resonance over lower half of right chest, with occasional moist clicking two inches above nipple; below this, respiration was absent; resonance of back same as before. Respiration distant, bronchial, with moist râles to inferior angle of scapula; absent below. No succussion.

May 29th. Respiration in front heard a little lower down, to within an inch of the nipple. There is still some fullness and hyperæsthesia of the side. Respiration heard half an inch below the inferior angle of the scapula, with moist râles.

May 30th. Aspirator used, and half a gill of ill-looking pus, with air, withdrawn. An incision was made into the pleura, and half a pint of

dirty pus followed the knife. On coughing, pus was thrown out in a jet, a distance of two feet. A drainage tube was inserted. At night the chest was washed out with a solution of carbolic acid.

May 31st. Slept much better the previous night, with one eighth of a grain of morphia.

June 1st. Cavity washed out twice daily. A large quantity of dirty pus flowed out in the morning. Complained of pain in right chest.

June 2d. Free discharge during night. Patient weaker. Face bathed with perspiration and blanched. Pulse quick and feeble. Six fountain syringefuls required to wash the cavity clean.

June 5th. Half a pint of pus escaped during night.

June 6th. One pint of pus discharged during night.

June 7th. One and a half pints of pus escaped during night; appetite improving.

June 8th. One and one third pints of pus came away during the night. One syringeful cleans the chest to-day.

June 12th. Patient improved; looks much better; appetite gaining. Less cough.

June 13th. Patient slept well without opiate. During the rest of the month condition improved. Discharge diminishing.

July 2d. Patient passed to the care of Dr. Draper. Broncho-vesicular respiration in front above line of incision. Indistinct bronchial respiration below. Entire flatness of back. Respiration easy. Marked improvement in general condition.

July 12th. Catheter slipped out this morning. Discharge past twenty-four hours has diminished; now very scanty; no pain; general condition excellent. Physical examination disclosed relative dullness throughout right lower lobe, but broncho-vesicular respiration may be heard to very base.

July 15th. Discharge had increased since last report; otherwise condition unchanged. Tube reinserted in intercostal opening, but not retained longer than a few hours.

July 17th. Intercostal opening made more free by inserting catheter, resulting in a free discharge of pus. Catheter was not retained.

July 25th. General condition improving. The right side was relatively fuller. Ribs immovable. Intercostal spaces filled. Relative dullness on right side, amounting to flatness below the nipple in front. In the back, dullness above the angle of the scapula; flatness below. Bronchial respiration above and within line of nipple on right side. Absence of respiration below nipple and in axillary space. Night-sweating.

August 1st. The resonance above the line of the incision is somewhat better. Broncho-vesicular respiration above the angle of the scapula everywhere. Bronchial respiration below that point to the

base of the lung. Wound discharging spontaneously and quite freely without syringing. General condition improving slowly.

August 8th. Respiration heard throughout the right lung to base; bronchial in character, with numerous fine, crepitant rales, heard at angle of scapula. Patient gaining in strength. Discharge of pus continues abundant and laudable. Region of wound granulating over a space two inches square.

August 9th. Patient wheeled out in the sun. Feels better for it.

August 21st. Discharged, relieved.

The temperature record in the foregoing case gave the following average variations:—

| | A. M. | P. M. |
|--|-------|----------------|
| From April 12 to May 3..... | 100° | 104° |
| After disappearance of typhoid, from May 3 to July 13... | 100° | 102° |
| From July 13 to July 24..... | 99° | 101.5° to 102° |
| From July 24 to August 21..... | 98° | 100° to 101° |

CASE XVIII. Miss T., a delicate girl eighteen years old, when nine years old had whooping-cough, followed by a bronchial irritability, supposed at the time to be of a tuberculous nature. This improved under cod-oil and tonics. Three years ago the cough again became troublesome, and Dr. E. H. Clarke found a pleural rub at the base of the left lung. Winter before last the cough increased. Last September the patient went to Mentone, where she improved during the winter, but the cough returned with the spring. On the journey home she reached London ill, and was placed under the care of Dr. Dobell. He is said to have stated, "There is general bronchitis with injury at the base of the left lung, though there is no existing tubercular trouble. She is in danger, and must pass her winter in a mild climate." She improved and gained flesh in London, but still on exertion had distressed breathing. On the passage from Liverpool she encountered severe weather, was very seasick, and had a rigor, followed by diarrhœa and cessation of the catamenia.

I first saw her on June 19th. She was very pale, emaciated, with an hectic flush, weak and nervous, without appetite, occasionally vomiting, with diarrhœa. There was dyspnœa on exertion, with a frequent harassing cough, and abundant muco-purulent expectoration, at times tinged with blood. Pulse 132; respiration 40. She passed the days sitting up in a straight-backed chair, being unable to lie down when in bed.

Physical examination. The right side was rounded, intercostal spaces somewhat filled, the integument œdematous. The right front was dull except in the clavicular region, where alone respiration was heard. The left front was resonant, with exaggerated breathing, with dry and

moist râles throughout, the latter coarsest and most abundant at the base. The apex beat of the heart was below and a little outside of the left nipple. The left back was like the front; the right back was dull in its upper third, and flat below. In the upper half was distant bronchial breathing, and very distant mucous râles through the lower half, evidently transmitted. An exploratory puncture was made, and half an ounce of purulent fluid withdrawn.

June 21st. The aspirator was used and twenty ounces of pure pus withdrawn. Temperature at six P. M. 100° .

June 22d. Patient passed a more comfortable day after the aspiration, though she had two severe paroxysms of coughing, the breathing being generally less oppressed. During the night she was vigilant, at times delirious. Two diarrhœic discharges. In the morning she seemed stronger and brighter, sitting half-raised in bed. Temperature 99.5° ; respiration 40.

June 27th. Condition unchanged; occasional vomiting with diarrhœa; harassing cough and copious expectoration; appetite very poor. Nights restless with delirium, quieted only by morphia. Paroxysms of dyspnœa. Pulse 120; respiration 35; temperature 100.5° to 102° . Aspirator again used; seven ounces of pus withdrawn.

July 1st. Patient somewhat improved; more color in the face; stronger; no diarrhœa past twenty-four hours. Temperature 99.5° ; pulse 126; respiration 40, but less difficult. Right front less dull, but the side and back extremely tender.

July 5th. Condition not as good. Dyspnœa and cough continue, with bloody muco-purulent expectoration. Stomach refuses even milk and lime-water; persistent diarrhœa. Patient weaker and more irritable. Respiration 40; pulse 140, weak, at times intermitting. Slight œdema about feet and ankles. Takes stimulants freely. Examination of chest shows the same condition, with slight dullness and bronchial breathing in upper fourth of left lung. After much persuasion the patient consented to have the aspirator used, when thirty-six ounces of pure pus were withdrawn, with increase of cough at the end of the operation.

July 7th. Patient very restless and exhausted; yawning, but sleepless. A permanent opening was advised.

July 8th. Quiet night; easier; carried down to piazza, where she passed two hours in the sun.

July 9th. Best night she had had for ten days. Takes food freely. Respiration 27; pulse 134.

July 10th. Last night again restless and wandering. Dyspnœa and "attacks of choking." Bloody expectoration. Vomiting. This morning respiration heaving, 36; pulse 132. Patient looks more weary.

July 12th. Patient seen by Dr. H. I. Bowditch, who also advised making a permanent opening by trocar, leaving canula in place, to be

done without ether on account of her dyspnœa. I plunged in a trocar two inches below the angle of the scapula; on its withdrawal pus freely followed.

July 16th. Yesterday morning the canula was changed for a shorter one. Last night patient was worried and delirious; had a constant short cough, with bloody expectoration. Since the shorter canula was introduced there has been less discharge of pus. A catheter meets with opposition at three fourths of an inch from the point of entrance, probably the thickened pleura. The canula, evidently being too short to reach the cavity of the pleura, was removed, and the longer one inserted, followed by a free discharge of pure pus to the amount of a pint.

During the rest of July and August the patient remained about the same, passing several hours daily on the piazza. Her appetite was very poor. Diarrhœa recurring every few days. Night-sweats were frequent. Respiration was always hurried. Cough was often very troublesome, with copious muco-purulent expectoration, at times bloody. There were occasional fits of depression, with hysterical crying; these were relieved only by morphine. Stimulants were freely taken.

During September there was a steady gain in strength, with improved appetite and digestion. The patient slept quietly all night. Two ounces of laudable pus were discharged during the twenty-four hours. The side was no longer over-sensitive, and was less prominent. The pleura was washed out twice a week. The lung was expanding. The patient walked about her rooms, and drove out every pleasant day.

September 25th Dr. Bowditch again saw her, and made the following note:—

"Percussion fairly equal in front. A little less in the upper three fourths of the right back than in the left. Respiration obscure, but heard through both fronts, somewhat roughened in both. More free in the left. Behind, the respiration is decidedly less than in front, especially in the right back; but on full respiration a squeak can be heard almost to puncture. Nowhere tubular respiration, or unusual vocal resonance."

During the month of October the improvement continued. On the 19th she came to Boston from Manchester, Mass., where she had passed the summer. She was not troubled by the trip.

October 25th Dr. Bowditch saw her with me. The pulse was 105, of good strength. Tongue natural. Face rounder and fuller. Appetite fair; digestion good. Percussion clear over both fronts; almost tympanitic. Respiration behind as at last examination, very distant, with sonorous râle on full inspiration heard at point of puncture. Half an ounce of pus was discharged daily. Most marked improvement in general condition.

October 27th she went to New York, arrived there comfortably, and has continued to improve up to the present date (November 22d).

RECENT PROGRESS IN DERMATOLOGY.¹

BY JAMES C. WHITE, M. D.

Horn upon the Glans Penis.—Professor Pick, of Prag, contributes to his journal² an account of a most interesting case of this rare affection. The patient, twenty-two years old, was received into the hospital in April, 1874, with balanoposthitis and several papillomatous growths upon the corona, also congenital phymosis. The operation for phymosis was performed, the condylomata removed, and their seat cauterized. Nine months later the patient returned with the horn full grown. The growth had started from the sulcus around its whole circumference, but upon one side it had developed much more rapidly than upon the other, so that taking a curved direction it had arched across and rested upon the shorter and opposite horn, forming a complete shield above the glans when in an erect position. The outgrowth was over two inches in length, measured along its outer curvature, and about half an inch in thickness. Dr. Pick refers to nine other cases on record of horns growing from the penis. The exceptional features in his are the age, inasmuch as they belong to old persons, and the rapidity of its growth, six months. Its origin was undoubtedly the papillomatous vegetations which preceded and were not completely destroyed. When the parts were left uncovered after the operation for phymosis, and became dry, then the epidermal new-growth had a chance to form and accumulate. After its amputation the papillæ were found greatly elongated, and large vessels were seen to penetrate between the masses of epidermal cells, of which it was composed, for nearly half its length. No sebaceous glands were found in the skin underlying the horn. The patient had psoriasis also, and Dr. Pick draws attention to the tendency to redundant epidermal formation in this affection, as shown in the excessive thickness of the nails and the exuberant growth of hair in many patients. The paper is accompanied by two colored plates of the growth, which perfectly exhibit its remarkable appearances.

Scleroderma.—Dr. Lagrange,³ in a treatise containing the reports of several cases, draws the following conclusions: (1) that scleroderma primarily consists of a chronic inflammation of the skin and subcutaneous cellular tissue, which may extend more deeply, attack the bones and articulations, and produce secondarily, by anatomical lesion of the peripheral nervous filaments, trophic disturbances, but of no great importance; and (2) that there is no evidence of the existence of any primary trophic disturbance, as no alteration in the spinal cord, nerves, or muscles can be determined.

¹ Concluded from page 643.² Vierteljahresschrift für Dermatologie und Syphilis, 1875, page 315.³ Contribution à l'Étude de la Sclérodémie, etc. Par A. Lagrange. Paris.

Purpura.—Professor Henock¹ reports four cases, all occurring in persons of fifteen years or younger, in which there were rheumatic pains in the joints, purpuric spots, intestinal colic and bloody dejections, and some fever. These symptoms were subject to relapses after apparent recovery, and were thus prolonged in one case three months. The purpuric spots were most marked upon the abdomen, genitals, and lower extremities. In a similar case reported by Wagner, albuminuria and membranous shreds in the dejections were observed, in addition to the above symptoms. The patient died, and purulent peritonitis and enteritis, with ulceration and deposits of false membrane within the intestine, were revealed.

Congenital Purpura.—Dohrn² reports a case of Werlhof's disease (morbus maculosus) in a pregnant woman. Of universal distribution, it disappeared before delivery, but the child showed the same spots, which also disappeared after a few days. New ones subsequently appeared on the conjunctiva and gums. The child was well developed.

Argyria.—Dr. B. Riemer³ reports a case of silver staining of the skin, and gives at great length the interesting results of his most valuable and minute investigations of the condition of the various tissues after death. The patient, forty-three years old, entered the Leipzig hospital in March, 1870, with tabes dorsualis. From this time until his discharge in May, 1872, on account of a beginning disease of the lungs, he took in all 5672 pills of nitrate of silver, equivalent to 34.032 grams (eight and a half drachms) of the salt, or 21.610 grams (five and a half drachms) of metallic silver. The first traces of staining were noticed upon the face at the end of a year, and after 2900 pills had been administered. He died a few days after his reëtrance to the hospital in November, 1873, with the gravest symptoms of tabes and phthisis. His skin at this time was universally of a grayish-blue color, most strongly marked upon the face, while the trunk, and especially the lower extremities, showed less of the gray tint. Some old scars upon the head stood out in bold contrast, from their white color. The coloration of the skin was the only symptom of the argyria during life. In addition to the skin, the following tissues were also found after death to be stained: The plexus choroidei was very dark-blue throughout its whole extent. In the brain and spinal tissues nothing was seen. The lungs showed no trace of staining; only in the larynx was a pale gray color of the mucous membrane noticed. The pericardium showed a little pigment. The intermuscular fibrous tissue of the heart contained large granules of the pigment, and in the endocardium it was

¹ The Medical Record, October 2, 1875; from Schmidt's Jahrbücher.

² Vierteljahresschrift für Dermatologie und Syphilis, 11 Jahrg., erstes Heft; from Archiv für Gynäkologie, 1874, No. vi.

³ Archiv der Heilkunde, 1875, page 298.

distributed in groups. The serous membrane of the stomach and intestine was colored gray, and the smallest arteries throughout, from the stomach to the rectum, were intensely silvered. The liver, kidneys, and spleen were also deeply discolored in parts. The organs most affected by the argyria were the glomeruli of the kidney, the plexus choroidei, the lining of the aorta, the mesenteric lymph glands, and the skin. The pigment was everywhere in a finely granular condition, and in the parts most deeply affected by aggregation of these particles large masses were formed. It was nowhere found connected with cell elements or deposited in or between them, but generally in the homogeneous membranes of connective tissue.

In what manner and form, and by what channels, does the silver reach these places of deposit? These are questions which have been differently answered by various observers. According to Frommann,¹ the silver albuminate dissolved in serum loses its solubility in some way after leaving the vessels, and is precipitated and reduced. Rouget² believes that the silver is contained in the blood as an albuminate soluble in the alkaline serum. Huet,³ although also a believer in the chemical theory of the existence of argyria, states that it must be deposited like foreign bodies. Virchow, on the other hand, maintains its production by physical laws, just as urates are deposited in gout and the lime salts (calcareous metastasis) in bone disease. Dr. Riemer concludes from his own observations in this case that it is a purely mechanical production, a deposit of pigment masses; that the pigment is received as such, that is, reduced silver, in the intestinal canal, here stored up to be transported through the channel of the lymph-vessels, and partly deposited on the way, partly and mostly carried into the blood. Suspended in this fluid the pigment reaches all parts of the body, penetrates through the wall of the vessel, leaving traces on its way, and finally comes to be permanently deposited in the tissues disposed to receive it. The process is similar, therefore, to anthracosis pulmonum and tattooing, although the extremely fine division of the reduced silver makes it unnecessary to call in the aid of the white blood corpuscles in transporting it. These conclusions he bases in the main upon his examination of the cutaneous tissues. An examination of the different strata of the skin, its glandular and other systems, reveals a peculiar fact; that is, the entire absence of the silver pigment in the epithelium, and this is all the more striking as in the deposit of ordinary pigment, under both physiological and pathological conditions, its principal seat is in the lower layers of the cells of the rete. In argyria the pigment lies close beneath the mucous layer, and is sharply defined as a

¹ Virchow's Archiv, xvii.

² Schmidt's Jahrbücher, 1874.

³ Journal de l'Anatomie et de la Physiologie, 1873.

black border. Its special seat, therefore, is that thin stratum of fibrous tissue which separates the corium from the rete, and belongs to the former. This dark seam is resolved by the microscope into the minutest granules, arranged in groups and streaks. It would seem as if the silver pigment tried to work its way outwards, as other foreign bodies are eliminated, through the skin, and found in the epithelial tissues above the corium an obstacle it could not penetrate, and thus collected in greatest abundance beneath it. The ever-increasing fineness and density of the net-work of fibrous tissue, as we reach the uppermost layer of the corium, also acts as a filter to hold back within its meshes the pigment granules. Certain fibres or bundles of fibres, especially those running parallel with the muscular system of the skin, were also stained of a reddish-brown color, which could not be resolved into granules, giving to the upper corium a streaked appearance. The deeper fibrous and subcutaneous cellular tissue, whose wider meshes formed an inefficient filter, were generally free from silver. An examination of the glandular systems gave very interesting results, confirmatory also of the above observations. The sweat glands were universally and without exception silvered, the pigment penetrating their secretory portion and depositing itself upon the membrana propria, but the cells and contents of the glands showed not the slightest trace of the metal. The non-secretory portions, or conducting-tubes, were scarcely at all discolored. The hair follicles were affected in a similar way; all the epithelial tissues remaining free from silver, the hair itself, its inner and outer root-sheaths and the contents of the sebaceous glands not showing a single metallic granule. The homogenous fibrous membranes of both systems, however, were affected, that of the hair follicle, the vitreous sheath, especially, showing both the granular deposit in groups and streaks, and the uniform staining of reddish-brown tint. Large granules were also constantly found deposited upon the papilla of the hair.

The lymph-vessels and nerve-tissues appeared to have no affinity for the silver, but the unstriped muscles and the blood-vessels were plainly affected. Many of the muscles exhibited a uniform granular deposit and were stained of a dark, almost black, color. This was most noticeable in those parts of the skin least abundantly supplied with the muscles. In the arteries the walls were found of a uniform gray tint, in consequence of fine granular deposit just where they diminish in size to become capillaries. The veins, on the other hand, showed not the slightest trace of silvering.

Which of all these sources of deposit are to be regarded as the principal agents in the production of the peculiar tint in argyria? In Riemer's opinion the blue element in it is due to the admixture of the vascular redness of the skin with the gray which belongs to the reduced silver, and which is the prevailing color as the skin loses its blood after

death in these cases. That we need not go deeper than the deposit in the uppermost layers of the corium to account for the tint is shown by the depth of color which a thin layer of pigment cells in the rete is capable of producing in the black races.

Dr. Riemer's investigations are valuable not alone for the information they supply concerning the nature of the process in argyria, but also for the very interesting facts they have brought to light upon points of anatomical and pathological importance.

Argyria from Local Application of Nitrate of Silver. — Duquet¹ reports a case in which a woman had her throat touched repeatedly with nitrate of silver, and after a time the whole skin was stained of a bluish color. He concludes that this was effected not so much by absorption from the ulcerated surface as from the stomach, into which the salt passed.

*Removal of Nitrate of Silver Stains.*² — A few grains of metallic iodine are placed in a vessel and a few drops of ammonia added. The solution is then applied by a brush or the finger to the stains, which rapidly disappear. The caution is given that the mixture is to be destroyed after using, lest an explosive compound result on drying.

Lupus. — Lang,³ professor of dermatology at the University of Innsbruck, communicates the most recent investigations upon the anatomy of this disease, which has attracted the attention of observers so much of late, and furnishes thirty-three figures in illustration of his microscopic examinations of tissue. His conclusions are concisely stated in his own words. Lupus is characterized by disturbances of nutrition which give rise to a continuous creation and destruction of fibrous, vascular, and epithelial growths; so that, according to the stage of the disease, at one time the progressive, at another the retrogressive products, now of this, then of that kind of tissue are presented to observation. One may always see, however, that cell proliferation (starting from the vessels) plays the principal part in the process, and that in the last stages of the disease not only resorption of growths in a state of retrogressive metamorphosis takes place, but also organization of cell new-growth into fibrous tissue is accomplished, by which the lupous skin acquires a cicatricial appearance without antecedent ulceration.

Piffard, in an article entitled *Histology of the Scrofulides*⁴ gives the results of his microscopic examination of the skin in various forms of disease which he calls scrofulides, and makes synonymous with lupus, according to the French school. Adenoma, hyperplasia of the rete, general small round-cell infiltration, cell-heaps, giant cells, concentric

¹ Medicinisch-chirurgische Rundschau, February, 1875; in *The Practitioner*.

² Medical Record, from *Le Bordeaux Médicale*, August, 1875.

³ Zur Histologie des Lupus. Vierteljahresschrift für Dermatologie und Syphilis, 11 Jahrg.

⁴ New York Medical Journal, August, 1875.

stratification of cells, and perivascular cell-sheaths were the appearances observed by him more or less uniformly. They lead him to conclude that some of the growths are benign, while others, namely, those characterized by the cell-heaps and cell-stratifications, are closely allied to epithelioma, and clinically may be found to terminate in the latter condition. The bearing of these interesting investigations upon the histology of lupus proper would be more satisfactorily established if, in view of his preference for French titles, Dr. Piffard had given some clinical account of the cases from which the specimens were taken.

Leprosy. — Dr. J. W. Ross, U. S. N., communicates¹ an account of a recent visit to the "leper institutions" of the Sandwich Islands, in which exceptional and extensive opportunity was afforded him of observing this interesting affection. The intimate commercial relations between the Hawaiian Islands and our Pacific States makes its study a matter of peculiar importance to ourselves. Dr. Ross, like others at these islands, is a believer in the propagation of the disease both by inheritance and by contagion, restricting the latter term to inoculation with the discharge from leprosy sores, thus placing it on a parallel with syphilis in this respect. Like syphilis, too, it is contracted in the great majority of cases during sexual intercourse, through the almost invariable abrasions and ulcerations of the genital organs. The anæsthetic form of the affection does not apparently manifest itself as prominently there as in other parts of the world, and the disease is also modified in its development and course by complication with syphilis. It attains its maximum in about ten years, and may last twenty-five or thirty years. Opinions differ among the resident physicians as to the date of its introduction into the islands, but it was exceedingly rare until about fifteen years ago, when it began to spread, and in 1865 had become so formidable that the Hawaiian government became alarmed and enacted a law banishing to a remote island all lepers and adjudging them civilly dead. The locality is described as beautiful, and everything is provided to make the isolation from the world tolerable. Since the establishment of the colony eleven hundred and ninety patients have been sent to it, eight hundred and ten of whom are still living. Upon another island near Honolulu a detention hospital has been built, where suspected cases are sent for detention until diagnosis is clearly established. Much greater unhappiness is said to prevail among its inmates than among the doomed residents of the farther island. In spite of these arrangements the disease is said to be on the increase, from a proportion in 1866 of one leper to every two hundred and fifty inhabitants to one in fifty in 1875. The reason given for this is that the late king was himself a leper, and prevented the thorough execution of the laws. Since his death they have been rigorously enforced, and the hope is now entertained that the disease will be rooted out.

¹ New Orleans Medical and Surgical Journal, September, 1875.

In the report on Norwegian leprosy by Hansen, referred to in the JOURNAL of June 3, 1875, in which the author attempts to show that the disease is contagious, and therefore not hereditary, he calls attention to the account given by Professor Boeck, after his recent visit to this country, of the condition of the Norwegian emigrants in our North-western States. In these colonies the only cases of leprosy are in persons born in the mother country, and the longest interval between emigration and its manifestation was fourteen years, not an impossible period of incubation, he thinks. He is of the opinion that the disease has in every case been brought to this country, or developed by intercourse with leprosy emigrants. He calls attention, moreover, to the fact that the earliest symptoms of the disease are often present long before they are observed. He regards America as affording the best field for the study of the question of the hereditability of the affection.

There can be no doubt that the transportation of leprosy from its old and historic centres to remote peoples, its quick reception and rapid extension among the Hawaiians, and its natural extinction in the centre of our own continent, offer data of the most important and interesting nature to the solution of its etiology. The question of its contagiousness is certainly well worth reopening.

Disturbances of the Skin in Progressive Muscular Atrophy.—Dr. Balmer¹ has collected a series of cases of this disease which were distinguished by disturbances of nutrition in the skin of the atrophied parts. The changes were mainly trophic disturbances upon the hands: tendency to inflammation of the bed of the nails, splitting and thickening of the nails, excoriations, fissures, ulcerations, and sometimes blisters upon the skin. Edematous and inflammatory swellings of the cutis and panniculus adiposus were also observed. The skin was at times livid, uniformly or in streaks. Hæmorrhages were observed too, and excessive perspiration of the hands. These cutaneous changes, the writer thinks, cannot be explained satisfactorily on Friedreich's theory of the myopathic genesis of the disease, but confirm the correctness of the views of those who regard progressive muscular atrophy as the result of disturbances of the sympathetic. In the cases recorded, at least, he regards the muscular atrophy, as well as the changes in the skin, to have been due to degeneration of its trunk, ganglia, and branches, or to functional disturbance of its vaso-motor and trophic centres.

The Relations of the Vaso-Motor System to the Production of Skin Diseases.—In an article on this subject Dr. Landgraf² reports several anomalous cases, which he refers to modified nerve action. One was a

¹ Archiv der Heilkunde, 1875, page 327.

² Archiv der Heilkunde, 1875, page 344.

lupus-like efflorescence upon the thigh, of twenty-seven years' duration; another was an acute pemphigoid eruption upon the fore-arm and hand; and the third was a diffused enlargement of the cutaneous capillaries over the whole body.

The Treatment of Tinea favosa by Petroleum. — Dr. H. Maccormac¹ has used this substance in a few cases. He mixes it with lard and rubs it twice daily into the scalp. His cases do not appear to have been long enough under observation to exclude the possibility of relapses.

Iodoform. — Dr. Lazausky,² assistant at the skin clinic at Prag, contributes an article on the therapeutical use of this substance, founded on its employment by Dr. Pick in one hundred cases of specific ulcers, ulcerations after bubos, ulcerating and moist condylomata, ulcerations after gummata, and ulcers of the leg. It was used externally in the forms of fine powder, suspension in glycerine and alcohol, and solution in ether (one part in fifteen), and internally in pill form. Its advantages over other methods are thus stated. The duration of the treatment is materially shorter; the methods of application are very convenient and therefore adapted to private practice; if economically used its high price is of little importance, because so little is required. To this end it should not be used in its state of coarse powder, but should be rubbed up as fine as possible. Its solution in ether is still better, as it can be applied more evenly, and the painted surface is immediately covered and protected by a fine, uniform coating of iodoform, which adheres firmly like collodion.

LEE ON SYPHILIS.³

LECTURES on Hunter would perhaps have been a more appropriate title for this collection of lectures, as may be inferred from the opening sentence of the author's preface: "The principal object of the present work is to illustrate some of Hunter's doctrines, which the lapse of time and the dissemination of more recent views have obscured or caused to be forgotten." Mr. Lee is an admirer of John Hunter, and with good reason, for Hunter certainly was amongst the first to throw a ray of light on the subject of venereal diseases, during the period that Bumstead so aptly calls the "age of confusion."

The author handles his subject *con amore*, and so identifies himself with his illustrious predecessor that it is frequently difficult, and at times impossible, to decide whether statements are his or Hunter's.

The first lecture takes us back to the age of humoral pathology. Blood has life and blood may be diseased, and cases are quoted to prove that syphilis

¹ The Practitioner, October, 1875.

² Vierteljahresschrift für Dermatologie und Syphilis, 1875, page 275.

³ *Lectures on Syphilis, and on Some Forms of Local Disease, affecting principally the Organs of Generation.* By HENRY LEE. Philadelphia: Henry C. Lea. 1875.

may be transmitted by the inoculation of syphilitic blood. The first two cases quoted from Hunter are not good examples of sound medical logic. Two patients had teeth transplanted (by the way, we thought that was a triumph of modern dental surgery), which fastened well and kept firm for a month. Then ulceration of the gum took place, the teeth loosened, and symptoms of secondary syphilis appeared. The conclusion drawn is that syphilis was transmitted by a tooth; we are not told that the subjects from whom the teeth were taken were suffering from syphilis, nor that there was any reason to suppose that the patients had not become infected in the usual way. These, however, are not fair examples of the illustrative cases, as we do not remember having ever seen so many cases of artificial inoculation brought together. Amongst the most interesting of these is a very full account of the almost general syphilization of the peasants of Lupara, in 1856, by Dr. Marone's using vaccine lymph containing syphilitic blood. Hunter's pathology of syphilis is accepted, and even indorsed, but we must feel a doubt as to whether "adhesive inflammation," "suppurative inflammation," "ulceration," and "mortification," would pass muster with pathologists of the present day, as telling the whole history of syphilitic disease.

On the vexed question of the classification of symptoms as secondary or tertiary, while admitting that "no such classification can be practically relied upon, either as a matter of pathology or with regard to treatment," he considers Mr. Lane's as the best. According to this, in brief, the affections of the skin and mucous membranes not resulting in deep and rapid ulceration, iritis, muscular pains, and periostitis, are placed in the secondary class; while the affections of fibrous membranes, nodes, caries and necrosis of bones, and serious ulceration of the skin and mucous membranes, are called tertiary. It is strange that this matter of classification should have been the cause of so much argument and contention, when the disease itself gives us such a clear dividing line between two classes of symptoms, from a pathological point of view: namely, all the affections of the skin, mucous membranes, periosteum, etc., which are the result of inflammation, whether it be called "adhesive" or "exudative," belonging to one class, which chronologically we may call secondary, and all those results of the development of a neoplasm, or new formation (gummata), whether in the skin, bones, or internal organs, forming a separate class, which we call tertiary.

This is hardly the place to enlarge on this point, but a little thought will convince any one that this marked difference in the two classes is a pathological truth. Mr. Lee refers to these new formations, or gummy tumors, as "deposits of lymph superficially organized," which, it is hardly necessary to say, is not in accordance with the teachings of cellular pathology.

While not of course agreeing with Hunter that gonorrhoea and syphilis are identical, Mr. Lee does believe that there is a form of urethral discharge which is a symptom of constitutional syphilis, and if we understand him rightly he further believes that this may be the only evidence of infection, that is to say, that in some cases the specific virus is absorbed by the mucous membrane of the urethra, and instead of causing an indurated chancre at the point of entrance, as it does when absorbed on the glans or prepuce, it simply creates a

subacute urethritis, the discharge resulting from which is contagious and inoculable. That Hunter should have thought gonorrhœa and syphilis identical is perhaps not to be wondered at, as by the crucial experiment of inoculating himself with what he took to be a gonorrhœal discharge he acquired syphilis, with the secondary symptoms of which he was troubled for three years.

Mr. Lee's views on the subject of syphilization are of interest, as next to Boeck he probably has investigated the matter more thoroughly and practically than any one since the days of Sperino. His conclusion is, "If, then, neither the suppurating venereal sore [chancroid] nor the primary, nor the secondary syphilitic affections, can be inoculated so as to produce any constitutional effect, it is hardly reasonable to suppose that any constitutional disease can be cured by either of these means."

In conclusion, we would say that the work under consideration is in no sense a systematic treatise on syphilis, nor is any new light thrown on the subject. As showing how near to the truth Hunter often came, it is interesting reading, and the author's treatment of the various subjects which he takes up is as a rule fair, concise, and logical. The lectures themselves, illustrated as many of them were by specimens from the Hunterian Museum, must have been extremely interesting to listen to.

F. B. G.

THE UNITED STATES MARINE-HOSPITAL SERVICE.¹

WE had occasion a year ago to express our cordial appreciation of the work done in this department of the public service, and especially to commend the labors of the supervising surgeon, Dr. J. M. Woodworth. The annual report of Dr. Woodworth, setting forth the operations of his bureau during the year ending June 30, 1874, maintains the high standard of his previous productions. The benefits which the seamen of the merchant service derive from the system of hospital relief established by national law in 1798 are of unquestioned importance, and these benefits are largely enhanced by efficient supervision and economical administration. We learn from the report that over fourteen thousand sick and disabled sailors were furnished with medical and surgical relief during the year; that the average cost per day for each patient was one dollar only; and that the mortality among the patients treated in hospitals was but three and one half per cent. Dr. Woodworth makes wise suggestions concerning the application of the provisions for hospital relief to many sailors who are now debarred in various ways; he also recommends certain reforms in hospital administration and in hospital construction, and intimates that there would be a large saving to the government, without loss of benefit to the seamen, if many of the expensive establishments now maintained were leased and reorganized as general hospitals.

We are glad to observe that preventive medicine has not been overlooked by the medical officers of the marine-hospital service. The hygiene of the forecabin is a prolific theme, and offers an excellent occasion for reformatory

¹ *Annual Report of the Supervising Surgeon of the Marine-Hospital Service of the United States, for the Fiscal Year 1874.* By JOHN M. WOODWORTH, M. D. Washington: Government Printing Office. 1874.

work. While the Plimsolls of the Old World are doing gallant service in protecting the sailor from the perils of "coffin-hulks," the medical men of the American mercantile marine are exposing the dangers to life and health which lurk about the scant accommodations usually provided on shipboard for seamen. Dr. Woodworth says in this connection, "So long as the average duration of a sailor's life continues to be only twelve years, — such low average being largely the result of the food he eats, the clothes he wears, the hole he sleeps in, and the excesses these conditions naturally and inevitably drive him to, — so long will continue the cry of 'unseaworthy sailors,' and so long will there be an inadequate supply even of these."

Besides the general report of the supervising surgeon, the book contains tables and charts setting forth the diseases treated in each of the districts into which the country is divided, and an appendix with various papers by medical officers connected with the service. We have space for only a brief mention of some of these contributions, premising in general, however, that they will all repay careful perusal.

Surgeon F. W. Reilly gives a spirited sketch of the American sailor of the present day, as compared with the class of men who, twenty years ago, reflected credit on our mercantile marine. He depicts the exposures of a seafaring life, the degenerating influences which surround the sailor's mind, body, and soul, the neglect which ship-owners and ship-masters permit. He alludes to the legal restrictions which have been made, and points out, in terms which we wish we could believe to be exaggerated, that these laws protect passengers but not sailors; that "poor food, wretched shelter, and a merciless task-mastery, enforced with steel knuckles and the belaying pin, . . . do not come within the scope of such legislation." All these matters, the writer says, are pointed out to demonstrate the necessity for reform, and to show the directions in which amendment is most needed.

A short paper, by Dr. A. B. Bancroft, describes the diseases which he has observed among the sailors who have come under his charge as patients in the marine hospital at Chelsea.

The diseases of sailors on the lakes, and of river men, are well discussed by medical officers having charge of hospitals in the Western States.

Finally, an elaborate analysis of the course of the yellow-fever epidemic in 1873 furnishes the theme of an interesting paper, in which Dr. Reilly discusses questions of quarantine and prevention, causes and treatment. The author's conclusion that "a quarantine of exclusion is impracticable, and a quarantine of detention is useless," will hardly pass without serious questioning by sanitarians; we fear that "the destruction of germs," "the prompt isolation of each case as it appears," and "a revolution in the sanitary conditions of water-side precincts," which are recommended as measures to secure immunity, would hardly suffice, alone, to assure the desired end. F. W. D.

OPIUM EATING.¹

TRASH. In our unflinching charity, we hope it is *honest* trash.

¹ *Opium Eating. An Autobiographical Sketch.* By an Habituate. Philadelphia: Claxton, Remsen, and Haffelfinger. 1876.

PROCEEDINGS OF THE SUFFOLK DISTRICT MEDICAL
SOCIETY.

JAMES R. CHADWICK, M. D., SECRETARY.

OCTOBER 30, 1875. The President, DR. H. W. WILLIAMS, in the chair.

Oxygen as a Corrective in the Anæsthetic Use of Chloroform and as an Antidote in Asphyxia.—The paper, by DR. A. YOUNG, will be published.

The Report on Sixteen Cases of Cataract Operations, by DR. B. J. JEFFRIES, was published in the JOURNAL of November 4, 1875.

A Case of Triplets was reported by DR. H. DOHERTY, of South Boston. Mrs. G. F., thirty-nine years of age, had had five children at full term and one miscarriage at two months. She was taken in labor at six P. M. on Monday, October 11, 1875, and three hours afterward gave birth to a female child, weighing three pounds, in a foot presentation. The pains continued until five o'clock on Tuesday morning. Dr. Doherty was first summoned at this time, and readily recognized the head of another child presenting, but not as yet engaged in the pelvis. Ergot was given to provoke uterine action, the membranes were subsequently ruptured, but the head had finally to be extracted by the forceps; it emerged with the face to the pubes. The child was a boy, and weighed five pounds. The interval between the two deliveries was twelve and a half hours. As the uterus remained hard and large, examination was again made, and the head of a third child was found presenting; it engaged at once and was delivered with the forceps in half an hour. The child was male, and weighed five and a half pounds. The placenta, which was detached with the hand to avoid the possible contingency of hæmorrhage, weighed with the cords and membranes two and a half pounds.

There had been no suspicion on the part of the woman that the pregnancy was plural, nor had her size or shape been unusual. The husband's mother and the wife's sister have each had twins once.

Statistics give the relative frequency of triplets as one in seventy-four hundred deliveries; the mortality of the children is one in three. All the children in the present case are now living, on the eighteenth day.

Extirpation of the Uterus by Abdominal Section with the Specimen.—The case, reported by DR. J. R. CHADWICK, appeared in the JOURNAL of November 4, 1875.

DR. W. H. BAKER raised a question as to the justifiability of performing so severe an operation for the removal of a tumor no larger than that now presented.

DR. CHADWICK said he thought that the grounds given in the report fully justified subjecting the patient to the risk; this had been the view taken by the Obstetrical Society, to which the question had been submitted.

Nitric Acid in the Treatment of Inflammatory Diseases of the Uterus.—DR. E. CHENERY reported great success with this practice in several cases. The first was endometritis, which had not yielded to the application of many other acids or to the use of the curette, but was speedily cured by nitric acid applied thoroughly to the whole inner surface of the organ after dilatation of the

cervix. In a case of retroversion attended with much pain and hæmorrhage, where the fundus was bound to the sacrum by adhesions, complete relief had been obtained by swabbing out the uterine cavity with nitric acid. The same satisfactory results had been derived from the application of nitric acid to the urethra in the later stages of gonorrhœa, and to ulcers on the genital organs. In all cases the reaction had been much less than after nitrate of silver, acid nitrate of mercury, etc.

DR. CHADWICK uttered a caution about the promiscuous use of nitric acid in dispensaries, or under any circumstances where the patient cannot keep quiet after its application. He had employed this acid in very many cases and had been much pleased with the results; but in several instances he had seen metritis and even peritonitis follow its use. The patients had all recovered, but had been the cause of much anxiety.

DR. G. H. BIXBY said that the danger was much enhanced when the acid was carried to the fundus; the application to that region, in his opinion, should be made only when the patient would keep her bed. His experience with nitric acid corroborated that of Dr. Chenery, especially in cases of menorrhagia. He never ventured to use the acid when the fundus was fixed by adhesions.

DR. G. H. LYMAN fully indorsed this practice. He had not supposed anyone would apply nitric acid to the fundus uteri in his office, and allow the patient to go home afterwards. He said that there was danger even in passing the sound, away from the patient's home.

DR. BAKER remarked that Atthill and other physicians had no hesitation in applying the acid to the whole uterine cavity in their office and dispensary practice.

THE TREATMENT OF INSANITY IN ENGLAND AND IN AMERICA.

A RECENT editorial in *The Lancet*,¹ on the treatment of insanity in America, recalls one of Mr. Hosea Biglow's moral reflections:—

“Of all the sarse thet I can call to mind,
England doos make the most onpleasant kind;
It's you're the sinner ollers, she's the saint;
Wut's good 's all English, all thet is n't ain't.”

It would be difficult to guess from what source the writer got his information, but we have no hesitation in saying that his statements are in letter and spirit utterly false; and we should be justified in using much stronger language. He says, “There can be no question that the custom of slave-holding and the brutalizing régime from which it is inseparable, have blinded and blunted the sensibilities of a people in other respects remarkable for their intelligence and enlightenment, to one of the most obvious and urgent teachings of modern science, namely, that mental derangement is distinctly a disease, and susceptible of relief or remedy by measures suitably devised and properly administered. It is surprising, but unhappily it is notorious, that in the United

¹ Vol. II., 1875, No. XX.

States the treatment of lunatics can hardly be said to have made much progress even in the stage of development which we have reluctantly described as the 'humane.' The sort of humanity which sways too many governors of asylums in the United States might indeed be inspired by a rule similar to that said to have been made for the officers of Bethlehem Hospital after the removal to Moorfields in 1675: 'No keeper or servant shall beat or ill-treat a lunatic without he considers it absolutely necessary for the governing of the lunatic.'"

To express the exact truth in regard to these assertions, we should be obliged to use a strong Anglo-Saxon monosyllable not in good use among gentlemen; and there are now in England many alienists who know enough of our institutions to say that we would be right in doing so.

It must be acknowledged that the want of frequent and thorough visitation of our asylums by persons not in any way connected with their government allows abuse in individual cases; but even in regard to these the language which we have quoted would be far too strong. The less said about the New York and Philadelphia city asylums, for instance, the better. The county asylum twelve miles from Chicago is still worse; it is a disgrace to our civilization; early in the past summer, out of about three hundred patients six were in irons. Of these six, three were fastened by a few iron links (the whole not over a foot long), connecting their handcuffs to a wall or to a chair. The only thing that can be said of such barbarous treatment is that it is used also to some extent in Russia.

Our State asylums, however, are very different institutions. The superintendents are picked men, selected for their intelligence and humanity; and any cruelty on their part would be followed by immediate discharge. As a rule, they give much more of their time to their patients than is done in England. It is these asylums to which allusion is made; for in the article referred to is the following statement: "They adhere to the old terrorism tempered by petty tyranny. They resort to contrivances of compulsion; they use, at least, the hideous torture of the shower-bath as a punishment in their asylums, although it has been eliminated from their jails. And, worse than all, if the reports that reach us may be trusted, their medical superintendents leave the care of patients, practically, to mere attendants, while devoting their own energies principally to the beautifying of their colossal establishments." Where in America can be found such "colossal establishments" as Colney Hatch, Hanwell, and the county asylums at Wakefield, Barming Heath, Prestwich, and Lancaster Moor?

We would remind the editors of *The Lancet* that the "humane" treatment of insanity was largely introduced in England by the efforts of a distinguished American philanthropist, Miss Dix; and that they need not go back to the parliamentary report of 1815 to find abuses and horrors in the treatment of mental disease such as never existed in the United States.

Mr. R. Gardiner Hill, once surgeon of the Lincoln Asylum, in describing the prevailing treatment of insane persons in England in 1840 (*British and Foreign Medical Review*, January, 1840, page 145) says, "The keeper or keepers kneel upon his body, thrust their knuckles into his throat, beat him, and bruise

him, until they succeed in overcoming him." We would respectfully refer the ignorant writer of the article in *The Lancet* to Mr. R. Gardiner Hill's book, on the Non-Restraint System of Treatment in Insanity, to the report of the select committee in 1859, to the minutes of the Lincoln Asylum, to the twenty-nine reports of the lunacy commission, to Mr. Arlidge's book on the State of Lunacy, and to two books by Dr. Conolly, *The Construction and Government of Lunatic Asylums*, and *The Treatment of the Insane without Mechanical Restraints*. Finally, if he has not convinced himself that only one third of a century ago the treatment of insanity in England was a blot upon their civilization, let him, if he has the heart to go farther, read a dozen pages of Miss Dix's private diary.

In 1773, the first insane asylum was established in the United States, and was conducted on "humane" principles. Three years previous to that time the managers of the Bethlehem Hospital ("Bedlam"), in London, were exhibiting their patients to the populace at a penny a head!

We grant that the best English asylums have far exceeded us in the rapidity of their improvement, that thirty years of supervision by the commissioners in lunacy have rendered systematic abuse and neglect of patients on the part of officers well-nigh impossible, that in abolishing mechanical restraint they have succeeded in reducing in a great degree the amount of medicine and seclusion used; but we would like to have the privilege of pointing out some of the seventy-two public and one hundred and forty private asylums where the treatment is certainly not intelligent, and where it seemed to us that there was what we in America should call neglect.

Does it not look as if in some, at least, of the English asylums the medical superintendents do not even "leave the care of patients, practically, to mere attendants," when the commissioners say, "For some years our attention has been directed to the large number of epileptic patients who are found dead in bed, and to the occurrence of suicides during the night, more especially in public asylums?"¹ Patients in our State asylums (our county asylums are more nearly allied to the English work-houses and poor-houses) are not left so much to the attendants as in England, and our attendants are not so brutal as the English. We have heard English superintendents acknowledge this fact; and they say freely to physicians, although not to the public, that the stories of broken ribs in English asylums are not simply the fictions of Mr. Charles Reade's fertile brain, but the sober, solemn truth.

For the benefit of a man who thinks that "the time has passed when a modest consciousness of our own shortcomings might restrain the impulse to remonstrate with the responsible managers of asylums in America," we will content ourselves with a few extracts from the Twenty-Eighth Annual Official Report of the Commissioners in Lunacy (London, 1874), although we must say that we find in them from year to year a *good deal* that is melancholy reading.

"In the case of a female patient, . . . who hung herself with a piece of tape which she had fixed to the casing of a water-closet door, some doubt arose whether the nurse in charge had been informed of this woman's suicidal disposition." (Page 29.)

¹ Twenty-Ninth Report, 1875, page 20.

"On the first of July it was discovered that he" (J. C.) "had fractures of the breast-bone, and also of three ribs on each side; . . . upon *post-mortem* examination, it was found that on the right side the third, fifth, sixth, eighth, ninth, tenth, and eleventh ribs were fractured, some in two or three places, and the fourth rib was detached from the breast-bone. On the left side, the seventh, eighth, ninth, tenth, and eleventh were broken and the fifth detached. There was a transverse fracture of the breast-bone opposite the cartilage of the fourth rib on each side." He was a patient "often requiring to be held." (Page 30.)

"Apart from the case of J. C. and the fatal violence, to which he was subjected, it appeared to us that there was strong evidence that the arrangements at the — asylum for the care and treatment of the impulsive and dangerous class of patients, especially in the male division, were very defective; . . . and above all that it was of the highest importance that there should be more vigilant and constant supervision of these departments of the asylum by Dr. — and the assistant medical officers." (Page 31.)

"That a patient with strong suicidal tendencies, and apparently not violent, should have been placed to sleep in a single room at all, and especially in one offering such facilities for accomplishing his object, showed great want of ordinary precaution." (Note on a case of suicide, page 34.)

That the circumstances of one accidental death showed "both laxity of discipline and great carelessness." (Page 34.)

"An old man was found two days after his admission to have received fractures of two or three ribs on the right side. . . . It appeared that he . . . 'fell, or was put down,' and that afterwards 'four or five of them' were about him and that he was pressed or knelt on." (Page 35.)

"We communicated to the medical superintendent our opinion that there was grave laxity of supervision." (Note on an "accidental death" from scalding in a bath-tub, page 37.)

"In the case of a male patient, whose death took place in March last, fractures of six ribs were discovered." (Page 38.)

"The death in this asylum of a male patient of strong and well-known suicidal disposition was so entirely due to negligence on the part of the chief attendant of the ward, that the resolution of the visitors that he should be severely reprimanded, but in consequence of his long service and excellent character should be allowed to retain his situation, appeared to the board the most lenient treatment for so serious an offense." (Page 39.)

"Shortly afterward another suicide of a female patient took place in the same asylum, when we again felt called upon to express our opinion that the attendants were to blame." (Page 40.)

"A male epileptic patient was drowned in a bath, which had been partly filled with water for the purpose of cleaning the ward, and into which he fell in a fit." (Page 41.)

"Three cases of suicide of patients belonging to — Asylum took place during the past year." (Page 41.)

"Portsmouth and Southampton continue without any efficient provision for their lunatics." (Page 44.)

"On inquiring into the circumstances, we came to the conclusion that this

lamentable event" (suicide by hanging, the patient having been dead several hours when seen) "was mainly attributable to a neglect of the most ordinary precautions." (Page 47.)

"The patient hanged himself from a ventilator, . . . where he was found dead in the morning." (Page 50.)

"A male private patient in this house was very severely assaulted on the 3d of December by two attendants named — and —, and he was found to have been so seriously injured as for a time to place his life in danger." (Page 52.)

But we will close this wearisome tale, merely referring our English friends to pages 53-63, 67, 69-71, 74, and 75, of the same report. The most deplorable accident of all was that by which England lost a most valuable citizen, Mr. Lutwidge, one of the commissioners in lunacy, killed by an insane man with a sharpened nail.

Dr. Manning, in his Report on Lunatic Asylums (1868), a work of unquestioned authority, states of the shower-bath in England, "In some asylums it is used as a means of correcting faulty habits, but for these purposes the shock only is required." (Page 121.) We would like to ask whether that means *punishment*. If the editor of *The Lancet*, in his "spirit of self-sufficiency," knows a single State or private insane asylum in the United States where the shower-bath is still used as a means of punishment, we would be very grateful to share his information.

We have already said that the writer of the article which we are criticising is ignorant. We can pardon him and the Earl of Shaftesbury (formerly chairman of the lunacy commission), whom he quotes, for saying that "the whole history of the world, until the era of the Reformation, does not afford a single instance of a single receptacle assigned to the protection and care of these unhappy sufferers, whose malady was looked upon as hardly within the hope of medical aid." The monks had an insane asylum at Jerusalem in the sixth century, and the ancient Egyptians had temples dedicated to Saturn for the cure of mental disease, which, in the matters of freedom from restraint, amusements, employments, etc., would put to the blush most of the English asylums of the present day. The Gheel colony dates from the seventh century.

This is not the place to discuss the question of mechanical restraint, except to say that the majority of American superintendents consider its use the *most humane* means at their disposal in certain cases.

We will close with a few extracts from three private letters received from the first authorities in England:—

"I am sorry to find that the locks, bolts, and bars which at one time rendered English asylums such prisons are still thought necessary in your part of the world. The greatest possible good has attended the abolition of these in England, and now many patients are allowed to walk out unattended on their parole, and rarely abuse the privilege." (November 5, 1875.)

"I must say that I think they" (American superintendents) "have not yet arrived at that point from which the treatment and management of the insane become easy, namely, the point where the doctor has no fear of his patient. . . . You have no idea, in the States, of the amount of freedom under due

supervision which our lunatics get; and it is constantly being increased, and with the best results. We are now pretty well rid of the old superstitious fear of the insane; and where the bounds of insanity have been so much enlarged it was time that this should be so." (October 31, 1875.)

"The neighborhood of London is about the worst we have for sample asylums. The old chartered hospitals for the insane are antiquated, and the new county asylums are vast receptacles for the insane, badly managed and governed. I do not think your hospitals for the insane of the McLean type are much behind the age, nor the State asylums in your States, barring the question of mechanical restraint; but some of your city asylums are really disgraceful to you as a people; those at — and — I can point to as iniquitous." (August 18, 1875.)

We welcome all such candid criticisms, based upon actual knowledge; but we have discarded the old rhetorical artifice of "slandering stoutly that something may stick."

MEDICAL NOTES.

— It is rather suggestive, not to say amusing, that while three or four homœopathic practitioners were before the city committee last Wednesday week with their roll of petitioners' names, to urge that a ward in the City Hospital be devoted to homœopathic treatment, and lamenting the absence of the petitioners themselves, their *first* and *chief* petitioner was at that very time convalescing under the care of a regular physician, having dismissed his homœopathic attendant some days previously.

— With regard to the Hospital Sunday, so called, the *Medical Times and Gazette* of November 19, 1875, says, "It will be seen that in the third year of its establishment, with improved coöperation and organization, the total amount realized is nearly £3000 less than on the previous occasions. Should another year's results tend in the same direction, it will become an imperative duty on the part of the council to consider whether the movement, as regards the metropolis, should not be at once abandoned as a serious failure."

The use made of a considerable part of the last collection taken in this city is not of a nature to commend the enterprise to the profession. Men who last year were excluded, this year come in for their pickings, and it is our impression that the quackish element will ere long leaven the whole mass.

— For the relief of neuralgic pain, Spencer Thompson, M. D., writes favorably of the employment of the tincture of gelsemium sempervirens. His paper may be found in *The Lancet* of November 6, 1875. Directly or indirectly the remedy has been used by Dr. Thompson or under his authority in at least forty cases of neuralgia, and with almost constant success. The remedial power of the agent seems to be applicable to neuralgia of those branches of the trifacial nerve supplying the upper and lower jaw, more particularly the latter; it is especially useful when the pain is most directly referred to the teeth or alveoli. The doses usually recommended are too small. Dr. Thompson almost invariably prescribes for an adult twenty minims of the tincture as a first dose, to be repeated any time after an hour and a half, if relief is not given. He has rarely had to order a third dose. Several cases are given to illustrate the successful employment of the drug.

— The recent death of Duchenne (de Boulogne) has called forth many testimonials relative to his untiring zeal as a physician, and his natural kindness of heart. The Paris correspondent of *The Lancet* gives some interesting facts regarding Duchenne's work and habits. He was born in 1806, and died at nearly seventy. After graduation he began practice in Boulogne-sur-Mer, his native place; but in order to obtain a larger field, particularly for his experimental work, he left for Paris, where, during thirty-three years, he led a life of incessant scientific labor. In 1847 he presented his first memoir to the Academy of Sciences, and till within a month of his death he continued to publish the results of his experiments and observations. His researches on the muscular system are among the most important of his works, and his studies on the muscles of the face, their office in the mechanism and expression of the human visage, are familiar in France to artists as well as to physicians. He is best known, however, for his researches on the nervous centres, on the various forms of paralysis, and on congenital or developed deformities. His name will ever be coupled with the history of progressive muscular atrophy, glosso-labio-laryngeal paralysis, and, generally, the microscopical anatomy and pathology of the nervous system. To Duchenne is due the honor of having methodically applied electricity to physiological and pathological investigations, and of having scientifically used it for the treatment of disease. He was a constant visitor in the wards of the Paris hospitals, and every morning could be seen there studying cases, examining specimens, and making drawings of microscopical appearances, in which latter accomplishment he was extraordinarily skillful. He showed wonderful keenness and ability in diagnosing cases of paralysis, and his honesty of purpose overcame the dislike which was manifested by the hospital physicians in the earlier years of his career. He was no orator, but was an excellent clinical instructor. He was dexterous and nimble in handling his patients, sharp and sensible in his questioning, most striking in the way he got up his data, made out the disease, and gave practical demonstrations of the study of his diagnosis. His patience was extraordinary, pursuing at times the investigation of a case for years. It may be said of him that under many adverse circumstances his reputation has come out clear and bright, as an honest, hard-working, acute, and ingenious observer, an original discoverer, a skillful professional man, and a kind-hearted, benevolent gentleman.

THE CASE OF HENRY WILSON.

[FROM OUR WASHINGTON CORRESPONDENT.]

MESSRS. EDITORS, — The medical event of the day which is interesting the profession here, as indeed it has profoundly affected the whole country, is the circumstances attending the illness and death of Vice-President Henry Wilson. The newspapers have kept us well informed respecting the progress of his case and the details of the post-mortem evidences. With regard to the stated cause of death (apoplexy), when taken in connection with post-mortem appearances, and as made public through the press, it would seem to be better that a reserved and qualified opinion had been expressed at the time, to give

opportunity for a more thorough and careful consideration of the condition presented.

While stating that the press here deserves credit for its accurate and correct accounts when taken in the main, exception must be made to the course pursued by one paper, the *National Republican*, which has sought to make a sensational article out of this unfortunate event, and by a badly-written, illogical, clap-trap account of the post-mortem examination, invests it with all the details that a morbid imagination might be supposed to conjure up in a dissecting-room scene; indeed, likening it to that, and striving to convey the impression that post mortems and dissections are to be classed together and both alike to be condemned. Were the character of this paper not well known here it might produce a pernicious effect in the community, but even straws may sometimes carry infection.

It may be well, however, to reproduce in a connected form and as an authoritative statement what has already been given to the world by the daily press.

We are told that the late vice-president suffered some two years ago from an attack of paralysis, the details of which were not familiar to the profession here, but a careful examination failed to connect the symptoms accompanying the recent illness as consequent upon the former attack of paralysis. The post mortem, indeed, showed a deposit of lymph upon the surface of the cerebral hemispheres which did not seem to be recent in its formation.

A few days before his late illness, Mr. Wilson had been under the treatment of Dr. Hammond for symptoms which occasioned the application of the actual cautery along the spine. On the morning of November 10th he was suffering from pain which extended from the base of the brain down the spine and into the limbs, and for relief took a hot bath, which resulted in prostration and an aggravation of the pains. At ten A. M. of the same day Drs. J. H. Baxter, U. S. A., G. L. Magruder, and F. A. Ashford were in attendance, in answer to an urgent summons. Counter-irritation of the surface with mustard and flannels was applied. There was no paralysis, but a heavy and listless condition, and with it an abrupt answering of questions and considerable twitching of the muscles, especially of those about the neck and face; at one time the face was drawn somewhat to the right side, but this was temporary. There had been constipation of the bowels; an enema was administered of castor-oil, turpentine, and warm water, bringing away semi-solid feces. Three large cups, improvised for the occasion from goblets, were now applied between the shoulders; these brought away one ounce of blood. The listlessness disappeared; solicitude and anxiety took its place, and the pain was still marked. The pulse was weak and small.

At 5.30 P. M. of the same day he was again seen by these medical gentlemen in consultation, having in the mean time been removed to the vice-president's room in the Capitol; he had taken his hot bath in a lower room of that building, and was there seized with the attack. It was found by the consulting physicians that he had taken since their last visit one dose of a mixture prescribed by them, which was equivalent to fifteen grains of bromide of potassium, one eighth of a grain of sulphate of morphia, and one drachm of cam-

phor water; a hypodermic injection of half a drachm of whisky had been administered. He had slept several hours, and expressed himself as greatly relieved and refreshed. He had urinated twice, and taken nourishment; there was no nausea or vomiting. Very little pain remained; the tongue was clean the pulse 72, and of good quality; the respiration was regular, 16; the pupils were regular, and responded well to light. The mind was clear. Weakness was extreme.

November 11th, 10.30 A. M., a consultation was held, but not at the bedside of the patient, he being in a comfortable sleep, with general symptoms favorable. Dr. Baxter had from the first, in accordance with the expressed wish of the vice-president, been acting as the attending physician, and from that time up to his death assumed sole charge of the case. There appears to be but little to add to this account of the onset of the attack, as in the opinion of Dr. Baxter the case appeared to progress satisfactorily, and two days before Mr. Wilson's death, had the weather been suitable, he would have been advised to drive out, and was encouraged to anticipate the journey North.

On the 15th there was an aggravation of the symptoms, due, it was supposed at the time, to the presence of visitors, to reading, and to injudicious additions to the diet-list without the doctor's sanction; with increased care in these particulars the symptoms subsided. Mr. Wilson throughout, and perhaps injudiciously, persisted in knowing the contents of his mail and of the newspapers of each day.

The circumstances immediately preceding his death are well told in the daily press as follows:¹—

"During the period previous to his death, while he was confined to his room, his physician, Dr. Baxter, denied admittance to all visitors except intimate acquaintances. But on Sunday he seemed to be in such excellent health and spirits, and was so very desirous of meeting his friends, the doctor relaxed the severity of the order, and quite a number of visitors were admitted to his chamber. With several of these he conversed quite cheerfully on various topics, and to nearly all expressed the belief that he would not be confined to his chamber much longer. He also, during the course of the day, expressed a desire to examine his correspondence, but this Dr. Baxter declined to permit, at the same time informing the vice-president that he feared the mental excitement which would naturally be produced in his then weak state by perusing important letters might prove injurious. Mr. Wilson felt considerable dissatisfaction at the strictness of the doctor's decision, and remarked to one of his attendants that a physician who would not tyrannize over his patients was a jewel rarely found, and added that he supposed sick people needed to be ruled with an iron hand for their own good. About four o'clock in the afternoon he fell into a refreshing slumber, which continued for three hours. When he awoke he informed his attendants that he felt much better than when he commenced to sleep, and spoke with them on general subjects until about eight o'clock, when he retired for the night. During the early portion of the night he slept very soundly, but a little after midnight he began to show signs of restlessness, and just before three o'clock he awoke very suddenly, complain-

¹ Washington Chronicle, November 23, 1875.

ing of a pain which had attacked his chest, soon after sinking into a sound sleep again, from which he did not awake until seven o'clock. Mr. Wood, who was the only attendant present, asked him concerning the manner in which he had slept, and also about his health. Mr. Wilson replied by saying that he had slept soundly, and felt very much refreshed. Mr. Wood then communicated to the vice-president the intelligence of the death of Senator Ferry, of Connecticut, which he had read in the morning papers. Mr. Wilson expressed his regret at the loss of his old friend, and made some few remarks, referring to the services that the senator had rendered his country. This seemed to bring home his own condition, and he incidentally alluded to his election to the vice-presidency, saying, 'If I live to the close of my present term, there will be only five who have served their country as long as I.' These were the last intelligible words uttered by Mr. Wilson. While speaking to Mr. Wood, Mr. Wilson was lying upon his bed, and appeared to be very comfortable; no evidences of pain were visible, and his manner and voice were very buoyant. About fifteen minutes after seven Mr. Wood opened a bottle of *Fredericshalle*, bitter water, which had been prescribed for the vice-president, and poured it in a tumbler and handed it to him to drink. Mr. Wood had scarcely turned, after removing the glass from the hands of Mr. Wilson, who sat up in bed to drink the water, when he heard a convulsive gasping, and on hastily looking he saw the vice-president in a half-recumbent position, with the weight of his body resting on his right hand, breathing stertorously, as if in pain. This lasted but a moment, however, when he fell back on the bed, still breathing heavily. He expired before Mr. Wood could do anything to relieve him."

From this it appears that death occurred about 7.15 A. M., November 22d. At 11.30 A. M. a post-mortem examination was made by Dr. Lamb, of the surgeon-general's office, assisted by Surgeon-General Barnes, Dr. Billings, Dr. J. H. Baxter, Dr. C. M. Ford, Dr. Ashford, and Dr. G. L. Magruder. Dr. Lamb has kindly furnished the following notes, which are more detailed than those published:—

"There was no rigor mortis, and no other external appearance of note except a longitudinal livid patch upon the back of the neck.

"The dura mater was quite firmly adherent to the inner surface of the calvarium adjacent to the longitudinal sinus; all of the sinuses were full of dark fluid blood; the pia mater was congested, and presented many small, old, whitish patches of lymph scattered along the surface adjoining the longitudinal sinus. The brain weighed forty-nine ounces, was normal in consistence and color, except that the puncta vasculosa were less marked than usual, both in number and in vividness; there was a transparent cyst about the size of a pea in the extremity of each choroid plexus; the ventricular fluid was normal in character and quantity. The subarachnoidal fluid was slightly increased in quantity. The arteries at the base of the brain, more especially the middle cerebrals and basilar, together with their larger ramifications, were notably atheromatous, some of the calcareous plates being three to four lines in long diameter, and so thick as nearly to obliterate the vessel. No thrombus nor embolus was found, nor any extravasation of blood in the venous plexuses of the pons Varolii or medulla.

"The spinal canal contained a large quantity of dark fluid blood. The spinal cord, which was examined as low down as the third dorsal vertebra, appeared to be normal, except that the demarkation between the gray and the white substance was not well marked. Portions of the brain and spinal cord were set aside for microscopical examination.

"The lungs were congested posteriorly; there were old pleuritic adhesions on the left side, chiefly around the apex; a calcareous deposit the size of a pea was found in the middle lobe of the right lung; the lungs were otherwise normal. The heart presented a small calcareous deposit on one of the segments of the aortic valve, but was otherwise normal. The pericardial fluid was normal in quantity and color.

"The stomach was much congested, the mucous membrane everywhere of a deep red color and covered with mucus. There were many erosions of the mucous membrane, some superficial, others nearly perforating the membrane; some, the smaller ones, were rounded, the larger were irregular in outline; these latter were surrounded by dark areolæ of congestion. The liver was of a dark color, congested, and somewhat friable; there was a small aqueous cyst in its upper surface, near the broad ligament. The gall-bladder was full of dark bile. The spleen was large and dark, but normal in structure. The kidneys weighed eight ounces each, and were congested; there were a few small subcapsular cysts and cicatrices, apparently of previous cysts. The bladder was contracted, its mucous membrane slightly reddened, and contained a small quantity of urine of normal color.

"The intestines appeared healthy.

"It ought to be stated, perhaps, that in view of the prospective embalming only such examination was made as appeared to be absolutely necessary.

"The cause of death was considered to be nervous apoplexy, depending probably on cerebral anæmia."

As to the condition of the stomach, Mr. Wilson was not a temperance man, properly speaking; although he advocated total abstinence from spirituous liquors, he was a large eater. Dr. Baxter at an early period in his attendance had diagnosed gastric derangement. The post mortem was performed by Dr. Lamb, who is an acting assistant surgeon, U. S. A., and an assistant at the Army Medical Museum, and may be considered an expert. Drs. Magruder, Ashford, and Ford are members of the profession in this city, and the remaining gentlemen are connected with the United States Army.

We are indebted for the most of these details, and for the confirmation of the published report, to Drs. Ashford and Baxter. Further details of the progress of the case will probably be given by Dr. Baxter at an early day, and in full. The spinal cord was removed to the extent of several inches for microscopical examination by Dr. J. J. Woodward, U. S. A., and in a few days the result will probably be made public.

The question very naturally arises, Was the cause of death assigned sustained by post-mortem evidence? This question, from the length of the letter and from prudential reasons, your correspondent leaves to other and abler minds to discuss.

HOMO.

WEEKLY BULLETIN OF PREVALENT DISEASES.

THE following is a bulletin of the diseases prevalent in Massachusetts during the week ending December 4, 1875, compiled under the authority of the State Board of Health from the returns of physicians representing all sections of the State:—

The following is a summary for each section:—

Berkshire: Bronchitis, pneumonia, rheumatism.

Valley: Bronchitis, pneumonia, influenza, typhoid fever, diphtheria. Greenfield reports an epidemic of influenza.

Midland: Influenza, bronchitis, pneumonia, rheumatism, diphtheria. Less diphtheria reported. Worcester returns scarlatina as prevalent.

Northeastern: Bronchitis, influenza, rheumatism, pneumonia. Less diphtheria and scarlatina. Natick reports "influenza universal and severe;" Haverhill, diphtheria severe and fatal.

Metropolitan: Bronchitis, scarlatina, pneumonia, diphtheria, influenza. No noteworthy change reported in the prevalence of diphtheria and scarlatina. Considerable diarrhœa coincidently with the sudden change to cold weather.

Southeastern: Influenza, bronchitis, diphtheria. Not much sickness.

For the State at large the summary, giving the order of relative prevalence of diseases, is as follows: Bronchitis, pneumonia and influenza (increased), rheumatism, diphtheria, typhoid fever (diminished), scarlatina and croup (increased), diarrhœa, measles, whooping-cough.

F. W. DRAPER, M. D., Registrar.

COMPARATIVE MORTALITY-RATES FOR THE WEEK ENDING NOV. 27, 1875.

| | Estimated Population. | Total Mortality for the Week. | Annual Death-Rate per 1000 during Week. |
|------------------------|-----------------------|----------------------------------|--|
| New York | 1,060,000 | 492 | 24 |
| Philadelphia | 800,000 | 262 | 17 |
| Brooklyn | 500,000 | | |
| Chicago | 400,000 | 115 | 15 |
| Boston | 342,000 | 162 | 24 |
| Cincinnati | 260,000 | 129 | 26 |
| Providence | 100,700 | 33 | 17 |
| Worcester | 50,000 | 14 | 15 |
| Lowell | 50,000 | 20 | 21 |
| Cambridge | 48,000 | 12 | 13 |
| Fall River | 45,000 | 24 | 28 |
| Lawrence | 35,000 | 9 | 13 |
| Lynn | 33,000 | 15 | 24 |
| Springfield | 31,000 | 7 | 12 |
| Salem | 26,000 | 12 | 24 |

Normal Death-Rate, 17 per 1000.

BOOKS AND PAMPHLETS RECEIVED.—Transactions of the American Otological Society. Eighth Annual Meeting. Vol. II. Part 1. Boston. 1875. (For sale by James Campbell.)

Annual Report of the Surgeon-General of the United States Army. 1875.